PROPOSED AMENDMENT

HB 1591 # 7

DIGEST

Proposed committee amendment to HB 1591.

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Delete everything after the enacting clause and insert the following:

SECTION 1. IC 2-5-36 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 36. Indiana Affordable Care Study Committee

Sec. 1. As used in this chapter, "Affordable Care Act" refers to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Sec. 2. As used in this chapter, "committee" refers to the Indiana affordable care study committee established by section 4 of this chapter.

Sec. 3. As used in this chapter, "exchange" refers to an American health benefit exchange established for Indiana under the Affordable Care Act.

Sec. 4. (a) There is established the Indiana affordable care study committee.

(b) The committee shall study and make recommendations concerning the following:

(1) The implementation of an exchange established for Indiana.

(2) The definition of "essential health benefits" for use in Indiana under the Affordable Care Act, including ensuring that the definition results in adequate benefits.

(c) The committee shall receive and consider annual reports from the office of the secretary of family and social services concerning the status and operation of the exchange established for Indiana.

(d) The committee shall, not later than November 1 of each year, report the committee's findings and recommendations concerning the committee's study under subsection (b) to the legislative council in an electronic format under IC 5-14-6.

Sec. 5. The committee shall operate under the policies governing study committees adopted by the legislative council.

Sec. 6. (a) The committee consists of the following voting members:

(1) Four (4) members of the senate, not more than two (2) of whom may be members of the same political party, appointed by the president pro tempore.

(2) Four (4) members of the house of representatives, not more than two (2) of whom may be members of the same political party, appointed by the speaker.

(3) The secretary of family and social services or the secretary's designee.

(4) The commissioner of the state department of health or the commissioner's designee.

(5) The commissioner of insurance or the commissioner's designee.

(6) One (1) member representing the insurance industry.

(7) One (1) member representing hospitals.

(8) One (1) member representing physicians.

(b) The president pro tempore shall appoint a chairperson of the committee during each even-numbered year. The speaker shall appoint a chairperson of the committee during each odd-numbered year.

Sec. 7. The affirmative votes of a majority of the voting members appointed to the committee are required for the committee to take action on any measure, including final reports.

Sec. 8. This chapter expires July 1, 2016.

SECTION 2. IC 12-15-2-17, AS AMENDED BY P.L.196-2011, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 17. **(a) Beginning January 1, 2014, the office may apply this section only to the following Medicaid applicants or Medicaid recipients:**

(1) An individual whose eligibility for Medicaid does not require a determination of income by the office, including an individual receiving Supplemental Security Income.

(2) An individual who is at least sixty-five (65) years of age if age is a condition of eligibility.

(3) An individual whose eligibility is being determined on the basis of being blind, disabled, or on the basis of being treated as blind or disabled.

(4) An individual who requests coverage for long term care services and supports for the purpose of being evaluated for an eligibility group under which long term care services or supports are covered, including the following:

(A) Nursing facility services.

(B) Nursing facility level of care services provided in an institution.

(C) Intermediate care facility services for the mentally retarded.

(D) Home and community based services.

(E) Home health services.

(F) Personal care services.

(5) An individual applying for Medicare cost sharing assistance.

~~(a)~~ **(b)** Except as provided in subsections ~~(b)~~ **(c)** and ~~(d),~~ **(e),** if an applicant for or a recipient of Medicaid:

(1) establishes one (1) irrevocable trust that has a value of not more than ten thousand dollars ($10,000), exclusive of interest, and is established for the sole purpose of providing money for the burial of the applicant or recipient;

(2) enters into an irrevocable prepaid funeral agreement having a value of not more than ten thousand dollars ($10,000); or

(3) owns a life insurance policy with a face value of not more than ten thousand dollars ($10,000) and with respect to which provision is made to pay not more than ten thousand dollars ($10,000) toward the applicant's or recipient's funeral expenses;

the value of the trust, prepaid funeral agreement, or life insurance policy may not be considered as a resource in determining the applicant's or recipient's eligibility for Medicaid.

~~(b)~~ **(c)** Subject to subsection ~~(d),~~ **(e),** if an applicant for or a recipient of Medicaid establishes an irrevocable trust or escrow under IC 30-2-13, the entire value of the trust or escrow may not be

considered as a resource in determining the applicant's or recipient's eligibility for Medicaid.

~~(c)~~ **(d)** Except as provided in IC 12-15-3-7, if an applicant for or a recipient of Medicaid owns resources described in subsection ~~(a)~~ **(b)** and the total value of those resources is more than ten thousand dollars ($10,000), the value of those resources that is more than ten thousand dollars ($10,000) may be considered as a resource in determining the applicant's or recipient's eligibility for Medicaid.

~~(d)~~ **(e)** In order for a trust, an escrow, a life insurance policy, or a prepaid funeral agreement to be exempt as a resource in determining an applicant's or a recipient's eligibility for Medicaid under this section, the applicant or recipient must designate the office or the applicant's or recipient's estate to receive any remaining amounts after delivery of all services and merchandise under the contract as reimbursement for Medicaid assistance provided to the applicant or recipient after fifty-five (55) years of age. The office may receive funds under this subsection only to the extent permitted by 42 U.S.C. 1396p. The computation of remaining amounts shall be made as of the date of delivery of services and merchandise under the contract and must be the excess, if any, derived from:

(1) growth in principal;

(2) accumulation and reinvestment of dividends;

(3) accumulation and reinvestment of interest; and

(4) accumulation and reinvestment of distributions;

on the applicant's or recipient's trust, escrow, life insurance policy, or prepaid funeral agreement over and above the seller's current retail price of all services, merchandise, and cash advance items set forth in the applicant's or recipient's contract.

SECTION 3. IC 12-15-3-1, AS AMENDED BY P.L.196-2011, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 1. (a) Except as provided in subsections (b) and (c) and section 7 of this chapter, an applicant for or recipient of Medicaid is ineligible for assistance if the total cash value of money, stock, bonds, and life insurance owned by:

(1) the applicant or recipient is more than one thousand five hundred dollars ($1,500) for assistance to the aged, blind, or disabled; or

(2) the applicant or recipient and the applicant's or recipient's spouse is more than two thousand two hundred fifty dollars ($2,250) for medical assistance to the aged, blind, or disabled.

(b) In the case of an applicant who is an eligible individual, a Holocaust victim's settlement payment received by the applicant or the applicant's spouse may not be considered when calculating the total cash value of money, stock, bonds, and life insurance owned by the applicant or the applicant's spouse.

(c) In the case of an individual who:

(1) resides in a nursing facility or another medical institution; and

(2) has a spouse who does not reside in a nursing facility or another medical institution;

the total cash value of money, stock, bonds, and life insurance that may be owned by the couple to be eligible for the program is determined under IC 12-15-2-24.

(d) This section expires December 31, 2013.

SECTION 4. IC 12-15-3-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 1.5. (a) Beginning January 1, 2014, the office shall determine eligibility for a Medicaid applicant or Medicaid recipient who is aged, blind, or disabled under IC 12-15-2-3.5.**

(b) If an individual:

(1) resides in a nursing facility or another medical institution; and

(2) has a spouse who does not reside in a nursing facility or another medical institution;

the total cash value of money, stock, bonds, and life insurance that may be owned by the couple to be eligible for Medicaid is determined under IC 12-15-2-24.

SECTION 5. IC 12-15-3-2, AS AMENDED BY P.L.196-2011, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 2. (a) Except as provided in section 7 of this chapter, if the parent of an applicant for or a recipient of assistance to the blind or disabled who is less than eighteen (18) years of age owns money, stock, bonds, and life insurance whose total cash value is more than one thousand five hundred dollars ($1,500), the amount of the excess shall be added to the total cash value of money, stock, bonds, and life insurance owned by the applicant or recipient to determine the recipient's eligibility for Medicaid under section 1 of this chapter.

(b) However, a Holocaust victim's settlement payment received by the parent of an applicant for or a recipient of assistance may not be added to the total cash value of money, stock, bonds, and life insurance owned by the applicant or recipient to determine the recipient's

eligibility for Medicaid under section 1 of this chapter.

(c) This section expires December 31, 2013.

SECTION 6. IC 12-15-3-3, AS AMENDED BY P.L.196-2011, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 3. **(a)** Except as provided in section 7 of this chapter, if the parents of an applicant for or a recipient of assistance to the blind or disabled who is less than eighteen (18) years of age own money, stock, bonds, and life insurance whose total cash value is more than two thousand two hundred fifty dollars ($2,250), the amount of the excess shall be added to the total cash value of money, stock, bonds, and life insurance owned by the applicant or recipient to determine the recipient's eligibility for Medicaid under section 1 of this chapter.

(b) This section expires December 31, 2013.

SECTION 7. IC 12-15-12-22.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 22.2. The office shall include in a contract entered into between the office and a managed care organization requirements for managed care organizations to actively implement policies that do the following:**

(1) Increase positive health outcomes.

(2) Promote personal responsibility and informed decision making by a Medicaid recipient concerning the Medicaid recipient's health.

(3) Promote the greatest degree of independence and use of community based supports, including home and community based services, for long term care.

(4) Prevent fraud, waste, and abuse by both Medicaid providers and Medicaid recipients participating in the program.

SECTION 8. IC 12-15-46-3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 3. (a) Before July 1, 2013, the office shall apply to the United States Department of Health and Human Services to amend the state Medicaid plan or for a Medicaid waiver to require a Medicaid recipient who is eligible for Medicaid based on the individual's aged, blind, or disabled status to enroll in the risk-based managed care program.**

(b) The office may apply to the United States Department of Health and Human Services for authorization to require other Medicaid population groups to enroll in risk-based managed care.

(c) The office may not implement the state plan amendment or Medicaid waiver described in this section until the office files an affidavit with the governor attesting that the state plan amendment or Medicaid waiver applied for under this section has been approved by the United States Department of Health and Human Services. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the state plan amendment or Medicaid waiver described in this section has been approved.

(d) The office shall, not later than October 1, 2013, implement the state plan amendment or Medicaid waiver described in subsection (a) if the state plan amendment or Medicaid waiver is approved by the United States Department of Health and Human Services and the governor has received the affidavit required under subsection (c).

(e) The office may adopt rules under IC 4-22-2 necessary to implement this section.

SECTION 9. IC 12-15-46-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 4. (a) Before July 1, 2013, the office shall apply to the United States Department of Health and Human Services for a state plan amendment or a Medicaid waiver requesting to implement a program for individuals who have an annual household income of not more than one hundred thirty-three percent (133%) of the federal income poverty level, as described in 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).**

(b) The request for a program in the state plan amendment or waiver described in subsection (a) must include the following components:

(1) Require a recipient to make out-of-pocket payments related to coverage for health care expenses provided under the program.

(2) Require a health care account to be used to pay the recipient's out-of-pocket health care expenses associated with health care coverage provided as part of the recipient's participation in the program described in this section.

(3) Include health care initiatives designed to promote the general health and well being of recipients and encourage an understanding of the cost and quality of care.

(4) Include coverage for preventative care services provided

at no cost to the recipient.

(5) Use of a managed care organization model for providing services to program recipients.

(6) Provision of the following services:

(A) Outpatient services.

(B) Inpatient services.

(C) Pharmaceutical services.

(D) Behavioral health.

(E) Other services determined by the office.

(7) Provide incentives for health behavior and encourage an understanding of the cost and quality of health care.

(8) Require to the fullest extent possible the use of home and community based services for long term care.

(c) The office may not implement the state plan amendment or waiver described in this section until the office files an affidavit with the governor attesting that the state plan amendment or Medicaid waiver applied for under this section is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified by the United States Department of Health and Human Services that the state plan amendment or Medicaid waiver described in this section is approved.

(d) If the office receives approval for a state plan amendment or a Medicaid waiver under this section and the governor receives the affidavit described in subsection (c), the office shall implement the state plan amendment or Medicaid waiver.

(e) The office may adopt rules under IC 4-22-2 necessary to implement this section.

SECTION 10. IC 12-15-46-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 4.5. (a) As used in this section, "Affordable Care Act" refers to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).**

(b) As used in this section, "exchange" refers to an American health benefit exchange established for Indiana under the Affordable Care Act.

(c) The Indiana health benefit exchange advisory committee is created for the purpose of advising the office with respect to policy

and program administration related to:

(1) an exchange established for Indiana under the Affordable Care Act consistent with the requirements of federal law; and

(2) implementation of a program under section 4 of this chapter.

(d) The governor shall appoint nine (9) members of the advisory committee as follows:

(1) One (1) member who is a representative of health consumer advocates.

(2) One (1) member who is a representative of small business.

(3) One (1) member who is a self-employed individual.

(4) One (1) member who has expertise in small employer health insurance coverage.

(5) One (1) member who has expertise in individual health insurance coverage.

(6) One (1) member who has expertise in administration of a health benefit plan.

(7) One (1) member who has expertise in administration of a public or private health care delivery system.

(8) Two (2) members who are eligible for or enrolled in Medicaid risk-based managed care implemented under sections 4 and 5 of this chapter.

(e) Three (3) individuals shall serve as ex officio members of the advisory committee, as follows:

(1) The commissioner or the commissioner's designee, who shall serve as chairperson.

(2) The secretary of family and social services or the secretary's designee.

(3) The commissioner of the state department of health, or the commissioner's designee.

(f) Members of the advisory committee:

(1) shall serve a three (3) year term;

(2) may be reappointed to successive terms; and

(3) serve at the pleasure of the governor.

(g) Members of the advisory committee shall serve without compensation. However, if sufficient money is available from federal grant funds or revenues generated by the exchange, each member may receive the per diem allowance and travel expenses provided for in rules that apply to executive committees adopted by the Indiana department of administration.

(h) The advisory committee shall do the following:

(1) Review and comment on policy initiatives related to quality improvement, health care benefits, and eligibility of individuals for coverage through the exchange and implementation of sections 4 and 5 of this chapter.

(2) Advise the department in setting budget priorities, including consideration of scope of benefits, beneficiary eligibility, health care professional reimbursement rates, funding outlook, financing options, and possible budget recommendations.

(3) Assess the effectiveness of implementation of sections 4 and 5 of this chapter.

(4) Not later than June 30 of each year, submit recommendations to the governor and, in an electronic format under IC 5-14-6, to the legislative council concerning the implementation of the exchange and of sections 4 and 5 of this chapter.

(5) Provide other advisory assistance as requested by the department or other agencies of the state.

SECTION 11. IC 12-15-46-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5. (a) The office shall apply to the United States Department of Health and Human Services for an amendment to the state Medicaid plan to do the following:**

(1) Require a recipient who has an annual household income of at least one hundred fifty percent (150%) of the federal income poverty level to make premium payments in order to participate in the program.

(2) Require Medicaid recipients to participate in cost sharing, as allowable under federal law.

(b) The office may not implement the state plan amendment described in this section until the office files an affidavit with the governor attesting that the state plan amendment applied for under this section has been approved by the United States Department of Health and Human Services. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the state plan amendment described in this section has been approved.

(c) The office may adopt rules under IC 4-22-2 necessary to implement this section.

SECTION 12. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "commission" refers to the health finance commission established by IC 2-5-23-3.**

(b) Before October 1, 2013, the office of Medicaid policy and planning shall present a plan to the commission concerning whether to increase Indiana's use of a risk-based managed care model to provide care to Medicaid populations currently being served under fee-for-service Medicaid. The plan must do the following:

(1) Provide an overview of what Medicaid populations in Indiana are currently being served under fee-for-service Medicaid.

(2) Review the use of risk-based managed care for Medicaid populations in other states, including Texas and Florida.

(3) Explain any determination that a current fee-for-service Medicaid population should continue to be served under the fee-for-service model.

(4) Make recommendations concerning the use of risk-based managed care for Medicaid recipients receiving long term care services.

(c) This SECTION expires December 31, 2013.

SECTION 13. **An emergency is declared for this act.**

(Reference is to HB 1591 as introduced.)